Health Attestation Forms

Health Attestation Form

Personal Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Contact Number:** _____
- **Email Address:** _____
- **Address:** _____

Health Declaration:

1. **Symptom Check** (Please check any that apply in the past 14 days):
    - Fever
    - Cough
    - Sore throat
    - Shortness of breath
    - Loss of taste or smell
    - None of the above
2. **Recent Health History:**
    - Have you tested positive for any infectious diseases such as COVID-19 in the past 14 days?
        - Yes
        - No
    - If yes, provide the date of diagnosis: _____
3. **Vaccination Status:**

- Are you vaccinated against COVID-19?
    - Yes
    - No
- If yes, please provide the date of your last vaccination dose: _____
- Type of vaccine administered: _____

4. **Travel History:**
    - Have you traveled internationally or to a community spread area in the past 14 days?
        - Yes
        - No
    - If yes, specify locations visited and dates: _____
5. **Exposure Risk:**
    - Have you been in close contact with anyone who has been diagnosed with an infectious disease such as COVID-19?
        - Yes
        - No

Certification and Signature:

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that providing false information may have serious consequences.

- **Signature:** _____
- **Date:** _____